Laura Mangum, RD, LD Consulting Dietitian
(512) 731.8679

CLIENT INFORMATION

Name: Social Security #: - - Date:

Address: City: Zip:

Phone:(hm) (wk) (cell) Email:

Ethnic Group: (circle) African-American Asian Caucasian Hispanic Other:

Sex of patient & subscriber (circle one): Male Female

Date of Birth: Referring Physician: Primary Physician:

Primary Insurance carrier: Type of Plan: HMO PPO POS

Primary Card Holder Name: Please select: His/Her Date of Birth:

Primary Card Holder's Employer Name:

Reason for Appointment:

OFFICE POLICIES

In order to effectively manage this small business and secure payment for our services, we have established the following policies: By initialing below, I understand that I have read and agree to written policies.

___ We require ***24-hour*** notice for canceling or rescheduling appointments. If we do not receive this advance notice, you will be charged a $50 missed appointment fee. This policy has been implemented in consideration for those clients who may be waiting for services.

___ It is customary to pay for professional services at the time of the appointment. As a courtesy, our office will file the claim with your insurance company, if you have nutrition coverage. However, the patient or responsible party will be responsible for any outstanding balances on the account. After 45 days, an outstanding balance will be charged to the credit card on file. If the account becomes delinquent, it will be turned over to a collection agency with an additional processing fee added.

___ I hereby authorize Laura Mangum RD, LD to file claims with my insurance company and to receive payment for professional services. **I also understand that I am financially responsible for all charges not covered by my insurance.** I further authorize payment directly to Laura Mangum of all insurance benefits related to my care. **I understand that I am responsible for any co-payments, deductibles, or co-insurance due at the time of any and all office visits.**

If a referral is required: (HMO plans)

___ We will require a copy of your insurance card; your co-payment, authorization number and the correct name of the insurance company or health plan to be billed. If this information has not been obtained we will expect full payment for the services or we will need to reschedule the appointment.

___ A copy of the official referral (obtained from insurance company) is required for HMO and Health Select plans, and must be obtained prior to the appointment or referral must accompany patient at scheduled office visit. If a referral is not on file at the time of the scheduled appointment, patient will be expected to private pay or reschedule.

lauramangum rd,ld
eat right. be fit. live well.

If your insurance is PPO or POS:

___ We will require a copy of your insurance card and specialist co-pay. Please check with your insurance company to make sure your diagnosis is covered prior to your appointment. If your insurance company declines coverage, you will be responsible for paying for services at the billed rate.

If you are private pay:

___ We require payment in full at the time of the appointment, by cash, check or credit card.

___ I authorize the release of any medical or other information necessary to process my claims. I request that payment be made to Laura Mangum RD, LD for these services. I understand that my insurance carrier may not cover payment for this service and therefore I will be responsible for payment.

___ I authorize Laura Mangum RD, LD to release medical information to the following providers:

1.) _____

2.) _____

3.) _____

___ I authorize Laura Mangum RD, LD to release medical information to the following family members/friends:

1.) _____

2.) _____

3.) _____

Signature:_____